

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 12/12/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/22/2013
Date of Injury:	3/19/1996
IMR Application Received:	8/2/2013
MAXIMUS Case Number:	CM13-0006317

- 1) MAXIMUS Federal Services, Inc. has determined the request for **retro Dendracin** is not medically necessary and appropriate.

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/2/2013 disputing the Utilization Review Denial dated 7/22/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/27/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **retro Dendracin (6/27/13)** is not **medically necessary and appropriate**.

### **Medical Qualifications of the Expert Reviewer:**

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The Expert Reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and treatments and/or services at issue.

### **Expert Reviewer Case Summary:**

The patient is a 57-year-old male who reported an injury on 03/19/1996. The mechanism of injury was not provided. The patient was noted to ambulate with the aid of a cane and to have tenderness in the lower lumbar paravertebral musculature. The patient was noted to have forward flexion of 60 degrees. The patient indicated that for breakthrough pain he alternates between Lidoderm patches and Dendracin lotion. The patient's diagnosis was noted to be failed low back surgery syndrome. The treatment was noted to be retro Dendracin lotion.

### **Documents Reviewed for Determination:**

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

**1) Regarding the request for retro Dendracin (6/27/13):**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the the Chronic Pain Medical Treatment Guidelines, Topical Analgesics section, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Salicylate Topicals section, pg. 105, which is a part of the MTUS.

Rationale for the Decision:

CA MTUS Guidelines recommend topical salicylates for chronic pain with documented evidence of the therapeutic effects. A review of the records indicates that the employee had subjective complaints of low back pain with some radiation into the lower extremities on 06/27/13. The employee, it was noted, that for breakthrough pain the employee alternates between Lidoderm patches and Dendracin lotion. The employee also noted that several months prior to the examination the employee had a fall. Objective findings included the employee ambulated with the aid of a cane. On examination, there was noted to be tenderness in the lower lumbar paravertebral musculature, and forward flexion of 60 degrees and extension of 10 degrees with lateral bending at 30 degrees. The strength in the lower extremities was noted to be globally intact and the sitting straight leg raise examination was noted to be negative bilaterally. It was noted the employee was given prescription refills for Lidoderm patches to apply every 12 hours #30 and Dendracin lotion 120 mL to apply as directed. The clinical documentation submitted for review indicated the employee had tenderness in the lower lumbar paravertebral musculature, was noted to be using Dendracin lotion for breakthrough pain. However, clinical documentation submitted for review failed to provide the efficacy of the requested medication per the guidelines. **The request for retro Dendracin**

**Effect of the Decision:**

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.